Coatesville Area School District
Parent/Guardian Questionnaire for Students with Asthma

Student Name _____ School: MBMS

School Year: Grade _____ Date _____

Dear Parent/Guardian,

You noted on the emergency card that your child has asthma. In order to give the appropriate care, we request that you complete this form and return it to the school nurse immediately. This information will be used to develop an individual action plan for your child.

If there is any change in this information during the school year, please notify the school nurse in writing.

Thank you,

School Nurse

Symptoms student has experienced in the past (please check all that apply)

___Coughing
___Hoarseness
___Dizziness
___Extreme weakness
___Abdominal cramps
___Wheezing
___Breathing difficulty
___Thickened speech
___Blue color of skin or lips
___Other _____

2. **Type of Asthma**: Exercise Induced_____ Allergic _____ Viral _____

3. **Medications needed**:

Name _____
Dose _____ Time _____

Name _____
Dose _____ Time _____

Special Instructions: _____

Name of Physician _____ Phone Number_____

I understand the above information will be used in an emergency action plan for my child. I give my permission to share this plan with my child's assigned teachers and appropriate personnel.

Signature of Parent/Guardian_____ Date_____